PROVIDER-BASED RURAL HEALTH CLINIC PROGRAM

(1) Authority. This is the payment methodology used to reimburse providers in the Medicaid Provider-Based Rural Health Clinic (RHC) Program.

(2) Qualifications. For a clinic to qualify for participation in the Medicaid Provider-Based RHC Program, the clinic must meet all of the following criteria:

(A) The clinic must be an integral part of a hospital, skilled nursing facility, or home health agency;

(B) The clinic must be eligible for certification as a Medicare Rural Health Clinic in accordance with 42 Code of Federal Regulations (CFR) 405 and 491; and

(C) The clinic must be operated with other departments of the hospital, skilled nursing facility or home health agency under common licensure, governance and professional supervision.

(3) General Principles.

(A) The Missouri Medicaid program shall reimburse provider-based rural health providers based on the reasonable cost incurred by the RHC to provide covered services, within program limitations, related to the care of Medicaid recipients less any copayment or other third party liability amounts that may be due from the Medicaid eligible individual.

(B) Reasonable costs shall be determined by the Division of Medical Services based on a desk review of the applicable cost reports and shall be subject to adjustment based on field audit. Reasonable costs shall not exceed the Medicare cost principles set forth in 42 CFR Part 405 and 413.

(4) Definitions. The following definitions shall apply for the purpose of this rule:

(A) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit;

(B) Division. Unless otherwise designated, division refers to the Division of Medical Services, a division of the Department of Social Services charged with the administration of Missouri's Medical Assistance (Medicaid) program;

(C) Facility fiscal year. The clinic's twelve (12) month fiscal reporting period that corresponds with the fiscal year of the hospital, skilled nursing facility, or home health agency that the clinic is based.

(D) Generally Accepted Accounting Principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing those principles.

(E) Medicaid Cost Report.

1. Hospital-Based RHCs. The documents used, for the purpose of reporting the cost of rendering both covered and noncovered services for the facility's fiscal year, shall be the cost reports defined in 13 CSR 70-15.010 Section (2)(C) and all worksheets supplied by the division.

2. Skilled Nursing Facility-Based RHCs. The documents used, for the purpose of reporting the cost of rendering both covered and noncovered services for the facility's fiscal year, shall be the Skilled Nursing Facility Medicare cost report forms and all worksheets supplied by the division.

3. Home Health Agency-Based RHCs. The documents used, for the purpose of reporting the cost of rendering both covered and noncovered services for the facility's fiscal year, shall be the Home Health Agency Medicare cost report forms and all worksheets supplied by the division.

(F) Provider or facility. A provider-based RHC with a valid Medicaid participation agreement in effect with the Department of Social Services for the purpose of providing RHC services to Medicaid eligible recipients.

(5) Administrative Actions.

(A) Annual Cost Report.

1. Each Provider-Based RHC shall complete a Medicaid cost report for the Provider-Based RHC's twelve (12)-month fiscal period.

2. Each Provider-Based RHC is required to complete and submit to the Division of Medical Services an Annual Cost Report, including all worksheets, attachments, schedules and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose.

3. All cost reports shall be completed in accordance with the requirements of this rule and the cost report instructions. Financial reporting shall adhere to GAAP except as otherwise specifically indicated in this regulation.

4. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. A single extension, not to exceed thirty (30) days,

may be granted upon the request of the Provider-Based RHC and the approval of the Missouri Division of Medical Services. The request must be received in writing by the division prior to the ninetieth day of the five (5) calendar-month period after the close of the reporting period.

5. In a change of ownership, the cost report for the closing period must be submitted within forty-five (45) calendar days of the effective date of the change of ownership, unless the change in ownership coincides with the seller's fiscal year end, in which case the cost report must be submitted within five (5) calendar months after the close of the reporting period. No extensions in the submitting of cost reports shall be granted when a change in ownership has occurred.

6. Cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report within the prescribed period, except as expressly extended in writing by the state agency, may result in the imposition of sanctions as described in 13 CSR 70-3.030.

7. Authenticated copies of agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material that must be submitted includes, but is not limited to, the following:

A. Audit, review or compilation statement prepared by an independent accountant, including disclosure statements and management letter;

B. Contracts or agreements involving the purchase of facilities or equipment during the last five (5) years if requested by the division, the department or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Schedule detailing all grants, gifts and income from endowments, including: amounts, restrictions, and use;

F. Documentation of expenditures, by line item, made under all restricted and unrestricted grants, gifts or endowments;

G. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

H. Leases and/or rental agreements related to the activities of the provider;

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I. Management contracts;

J. Provider of service contracts; and

K. Working trial balance used to prepare cost report with line number tracing notations or similar identifications.

8. Under no circumstances will the division accept amended cost reports for final settlement determination or adjustment after the date of the division's notification of the final settlement amount.

(B) Records.

1. Maintenance and availability of records.

A. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this regulation, including reasonable requests by the division or its authorized agent for additional information.

B. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

C. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand.

D. The Missouri Division of Medical Services shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the recordkeeping requirements of 42 CFR 413.20.

E. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than five (5) years.

2. Adequacy of records.

A. The division may suspend reimbursement or reduce payments to the appropriate fee schedule amounts if it determines that the provider-based RHC does not maintain records that provide an adequate basis to determine payments under Medicaid.

B. The suspension or reduction continues until the provider-based RHC demonstrates to the division's satisfaction that it does, and will continue to, maintain adequate records.

(C) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider. This person must be capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location that is different from the site where services were provided, the provider shall transfer the records to the same facility at which the services were provided, or the provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

(D) Change in Provider Status. The next payment due the provider after the division has received the notification of the termination of participation in the Medicaid program or change of ownership may be held by the division until the cost report is filed. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released.

(6) Nonallowable Costs. Cost not related to provider-based RHC services shall not be included in a provider's costs. Nonallowable cost areas include, but are not limited to, the following:

(A) Bad debts, charity and courtesy allowances;

(B) Return on equity capital;

(C) Capital cost increases due solely to changes in ownership;

(D) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, but excluding organizational costs;

(E) Attorney fees related to litigation involving state, local or federal governmental entities and attorneys' fees that are not related to the provision of provider-based RHC services, such as litigation related to disputes between or among owners, operators or administrators;

(F) Central office or pooled costs not attributable to the efficient and economical operation of the facility;

(G) Costs such as legal fees, accounting costs, administration costs, travel costs and the costs of feasibility studies that are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;

(H) Late charges and penalties;

(I) Finder's fees;

(J) Fund-raising expenses;

(K) Interest expense on intangible assets;

(L) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals. Costs associated with portions of the physical plant used primarily for religious functions are also nonallowable;

(M) Research costs;

(N) Salaries, wages or fees paid to nonworking officers, employees or consultants;

(O) Value of Services (imputed or actual) rendered by non-paid workers or volunteers; and

(P) Costs of services performed in a satellite clinic, which does not have a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing provider-based RHC services to Medicaid eligible recipients.

(7) Interim Payments.

(A) Hospital-Based RHCs. Provider-based RHC services that are an integral part of the hospital, unless otherwise limited by regulation, shall be reimbursed on an interim basis by Medicaid based on the clinic's usual and customary charges multiplied by the lower of one hundred percent (100%) or one hundred percent (100%) of the Medicaid-allowable hospital outpatient cost-to-charge ratio as

determined by 13 CSR 70-15.010 (13) (D) Interim payments shall be reduced by copayments and other third party liabilities.

(B) Skilled Nursing Facility-Based RHCs and Home Health Agency-Based RHCs. Provider-based RHC services that are an integral part of the skilled nursing facility or home health agency, unless otherwise limited by regulation, shall be reimbursed on an interim basis by Medicaid based on the clinic's usual and customary charges multiplied by the lower of by the Medicare RHC rate or the rate approved by the Division of Medical Services. Interim payments shall be reduced by copayments and other third party liabilities.

(8) Reconciliation.

(A) The state agency shall perform an annual desk review of the Medicaid cost reports for each provider-based RHC's fiscal year and shall make indicated adjustments of additional payment or recoupment, in order that the provider-based RHC's net reimbursement shall equal reasonable costs as described in this section.

(B) Notice of program reimbursement. The division shall send written notice to the provider-based RHC of the following:

1. Underpayments. If the total reimbursement due the RHC exceeds the interim payments made for the reporting period, the division makes a lump-sum payment to the RHC to bring total interim payments into agreement with total reimbursement due the RHC.

2. Overpayments. If the total interim payments made to an RHC for the reporting period exceed the total reimbursement due the RHC for the period, the division arranges with the RHC for repayment through a lump-sum refund, or, if that poses a hardship for the RHC, through offset against subsequent interim payments or a combination of offset and refund.

(C) The annual desk review will be subject to adjustment based on the results of a field audit that may be conducted by the division or its contracted agents.

(9) Sanctions.

(A) The division may impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services or any other sanction authorized by state or federal law or regulation.

(B) Overpayments due the Medicaid program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

(10) Appeals. In accordance with sections 208.156 and 621.055, RSMo (1994), providers may seek hearing before the Administrative Hearing Commission of final decisions of the director, Department of Social Services or the Division of Medical Services.

(11) Payment Assurance.

(A) The state will pay each RHC, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the RHC according to the standards and methods set forth in the regulations implementing the RHC Reimbursement Program.

(B) RHC services provided for those recipients having available Medicare benfefits shall be reimbursed by Medicaid to the extent of the coinsurance and deductible as imposed under Title XVIII.

(C) Where third-party payment is involved, Medicaid will be the payor of last resort.

(D) Regardless fo changes of ownership, management, control, leasehold interest by whatever form for any RHC previously certified for participation in the Medicaid program, the department will continue to make all the Medicaid payments directoly to the entity with the RHC's current provider number and hold the entity with the current provider number responsible for the Medicaid liabilities.

(12) Payment in Full. Participation in the Medicaid program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these regulations and applicable copyaments.

DIABETIC EDUCATION AND SUPPLIES

The state agency will establish rates for reimbursement as defined and determined by the Division of Medical Services in accordance with 42 CFR 447 Subpart D. Reimbursement will be made at the lower of:

1. The provider's billed charge for the service or

2. The Medicaid maximum allowable fee for the service.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) - PRE-PAID HEALTH PROGRAM

The state agency will establish rates for reimbursement as defined and determined by the Division of Medical Services in accordance with 42 CFR 447.361.

This is a Pre-Paid Health Program. A capitated rate will be paid to the Health Plan each month for each enrolled Medicaid recipient. Partial months will be prorated. Recipients will receive specified services from the Health Plan. Other services will be available through the Medicaid fee-for-service program. The program is cost-neutral. Recipients are appropriate for nursing home care and the capitated rate paid to the Health Plan should be no more than the Medicaid cost for services provided for individuals residing in Nursing Homes in the service area.